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State/Territory Name: Georgia

State Plan Amendment (SPA) #: GA-24-0039 and GA-24-0041

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

July 22, 2024

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Martin Luther King Jr. Drive, SE
19th Floor, East Tower
Atlanta, GA 30334

Dear Stefanie Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number GA-24-0039, submitted on February 8, 2024 with additional information received on July 16, 2024, has been approved. The companion SPA number GA-24-0041, submitted on May 2, 2024 has also been approved. The effective dates for these SPAs are January 1, 2024 and October 1, 2024, respectively.

Through GA-24-0039, Georgia provides 12 months of continuous eligibility (CE) coverage to individuals enrolled in its separate CHIP, pursuant to section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023). Section 5112 of the CAA, 2023 amended titles XIX and XXI of the Social Security Act to require that states provide 12 months of CE for children under the age of 19 in Medicaid and CHIP. In Georgia, this provision applies to targeted low-income children. Further, Georgia confirms the state will not disenroll children from coverage due to late premium payments during or at the end of the CE period. A copy of the approved CS21 and CS27 state plan pages are attached to be incorporated into the state's approved CHIP state plan.

Through GA-24-0041, Georgia is aligning section 8.7 with companion SPA GA-24-0039 to update the description of timeframes, notice requirements, and consequences for an enrollee or applicant who does not pay a cost sharing charge. Also through this SPA, the state waives the collection of all CHIP premiums through September 30, 2024 and resumes premium collection effective October 1, 2024.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

Sarah deLone
Director

Section 1:

State of Georgia State Plan Amendment number: GA-24-0041

This State Plan Amendment will update the following sections:

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

SPA number: GA-24-0041

Purpose of SPA: This is a companion SPA to amend section 8.2.1 verbiage regarding Georgia's DRAL to waive premiums through 9/30/2024 and to align section 8.7 with GA-24-0039 to provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c)).

Proposed effective date: 10/01/2024

Proposed implementation date: 10/01/2024

8.2.1. ☒ **Premiums:**

Premiums are not required for children ages 0-5 years old. American Indians/Alaska natives and children in Foster Care are also exempt from paying a premium. For children ages 6-18, the premiums are detailed in the table below:

FPL	One Child	Family Cap
139%-158%	11.00	$16.00
159%-170%	22.00	$44.00
171%-190%	24.00	$49.00
191%-210%	29.00	$58.00
211%-231%	32.00	$64.00
232%-247%	36.00	$72.00

The State assures that continuous eligibility is provided through an individual's 12-month Post-Partum period regardless of non-payment of premiums, or an individual becoming eligible for Medicaid.

At State discretion, premiums may be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in State or Federally declared disaster areas for a specified period of time.

Through Georgia's DRAL dated May 10, 2023, the state waived premiums for all CHIP enrollees through December 31, 2023. The state will continue waiving premiums through 9/30/2024.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c)):

Applicants will be given forty-five (45) days from the date the application is processed to make their initial premium payment. When the initial premium payment is received, the applicant will be enrolled in PeachCare for Kids®, and eligibility will be effective the first day of the month in which the application was submitted. There will be one late notice sent to the applicant if their initial premium payment has not been received within thirty (30) days of initial authorization of the application. The notice will notify the member that their case will be denied if their premium payment is not received by the 45*th* day. The denial letter will be sent with timely notice which includes an explanation of the applicants Fair Hearing Rights. If the initial premium payment is not received the case will be denied.

Late notices will not be sent after the initial premium payment is received. Enrollees do not lose coverage for non-payment of premiums after the initial premium payment is received for each new enrollment period, which includes the initial eligibility determination at application and annual renewals.

PCK members submitting renewal and documentation timely will be given 30 days from the date the renewal is processed to make their initial premium payment for the new period of eligibility. When the

initial premium payment is received, eligibility will be effective the first day of the month following the renewal month. There will be one late notice sent to the member if their initial premium payment has not been received within 15 days of the authorization at renewal. The notice will notify the member that their case will be closed if their premium payment is not received by the 30*th* day. The notice will be sent with timely notice which includes an explanation of the applicants Fair Hearing Rights. Families who are closed due to non-payment of premium are notified and informed of their right to a review of the termination.

Applicants that do not return their renewal timely will be terminated and provided a Ninety (90) day reconsideration period to submit their renewal. A new application is not required during this 90-day reconsideration period. PCK members submitting renewal and documents during the reconsideration period will be given 30 days from the date the renewal is processed to make their initial premium payment for the new period of eligibility. The period of eligibility will begin on the first day of the month after the termination date once premium payment is received. If premium payment is not received the case remains terminated.

There is no lock out period for non-payment of premiums.

~~Premiums are due the first of the month, prior to the month of coverage. If a premium payment is not received on the first, a late letter is sent to the family approximately four days after the late premium was due informing them that if payment is not received by the end of the month, they will be given 45 days of grace period before the coverage termination process begins, with coverage being canceled at the end of the 2nd month of the grace period. If the family does not pay the past due premium at the end of the month that it is due, the grace period begins the following month. The State will send a notice no later than the 8th of the first grace period month, informing the family that failure to make a premium by the 15th of the 2nd grace period month will initiate the termination~~

~~process and coverage will ultimately be terminated at the end of the 2nd grace period month. If the premium is not paid by the 15th of the 2nd grace period month, then the coverage termination process begins and is ultimately terminated by the end of the 2nd grace period month, unless the family makes a premium payment by the end of the 2nd grace period month. Payments received after the 15th day of the 2nd grace period month will stop the termination process, and the family will remain enrolled. Families who are canceled due to non-payment of premium are notified by mail and informed of their right to a review of the termination.~~

~~In the case that a premium payment is made during the grace period, but there is still an outstanding premium(s), the payment would apply to the first missed premium payment. The grace period would then start again based on the date of the second missed premium payment such that a family always has a grace period starting at the first of the month of a new coverage period and ending 45 days later.~~

~~There is no lock out period for non-payment of premium. The family may make a payment within 90 days of the case terminating and the case will be re-opened without the need to re-apply.~~

~~For example, on January first the premium is due for February coverage. If a family missed the January 1st due date, a letter is sent to the family on approximately January 4th informing them that their payment is due and that if payment is not received by the end of January, the grace period will begin on February 1st and last until March 15th, after which the coverage termination process will begin. If the family does not pay the January 1st premium due for February coverage by the 15th of March, the termination process begins, and the family's coverage is terminated at the end of March. However, if the family makes a premium payment by the end of March, the termination process is stopped, and the family remains enrolled.~~

~~In the case where a family missed the January 1st and the February 1st premium, but made a single premium payment by February 15th , the payment would apply to the January missed payment and the family would be offered a new premium grace period starting on March 1st and requiring payment by April 15th before coverage is terminated. In the case where a family missed the January 1st premium, the February 1st premium, but made a single premium payment by March 15th, the February 1st premium due for March coverage would be required by April 15, after which coverage would end April 30. This cycle will continue for each new month of coverage and each grace period, where premium payments are late. Any late premium payments will always apply to the earliest premiums due.~~

Exception to Disenrollment for Failure to Pay Premiums

At State discretion, initial premiums will be waived at application and/or renewal, for existing beneficiaries and new applicants who reside and/or work in a State or Federally declared disaster area.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

CHIP Eligibility

State Name: Georgia

OMB Control Number: 09381148

Transmittal Number: GA - 24 - 0039

Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums	**CS21**
42 CFR 457.570	
Non-Payment of Premiums	
Does the state impose premiums or enrollment fees?	Yes
Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

CHIP Eligibility

State Name: Georgia

OMB Control Number: 0938-1148

Transmittal Number: GA - 24 - 0039

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2107(e)(1)(K) of the SSA and 42 CFR 457.342 and 435.926; 2107(e)(1)(J) and 1902(e)(16) of the SSA

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period Yes

☒ The state assures the extended postpartum period available to pregnant targeted low-income children or targeted low-income pregnant women under section 2107(e)(1)(J) of the SSA is provided consistent with the following provisions:

- ☒ Individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA

☒ Continuous eligibility is provided to targeted low-income children who are pregnant or targeted low-income pregnant women (if applicable) who are eligible for and enrolled under the state child health plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

- ■ The individual or representative requests voluntary disenrollment.
- ■ The individual is no longer a resident of the state.
- ■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to the individual.
- ■ The individual dies.

Unlike continuous eligibility for children, states providing the 12-month postpartum period may not end an individual's continuous eligibility due to becoming eligible for Medicaid.

- ☒ Consistent with section 2107(e)(1)(J) of the SSA, the state assures that continuous eligibility is provided through an individual's pregnancy and 12-month postpartum period regardless of an individual becoming eligible for Medicaid.

☒ Benefits provided during the 12-month postpartum period must be the same scope of comprehensive services consistent with the benefit package elected by the state under section 2103(a) of the SSA that is available to targeted low-income children and/or targeted low-income pregnant women and may include additional benefits as described in Section 6 of the CHIP state plan.

CHIP Eligibility

Mandatory Continuous Eligibility for Children

The CHIP Agency must provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, for a 12-month continuous eligibility period.

☒ Consistent with section 2107(e)(1)(K) of the SSA, the state assures that continuous eligibility is provided to its targeted low-income children for a duration of 12 months, regardless of any changes in circumstances, unless:

- ■ The child attains age 19.
- ■ The child or child's representative requests voluntary disenrollment.
- ■ The child is no longer a resident of the state.
- ■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.
- ■ The child dies.
- ■ The child becomes eligible for Medicaid.

The state elects to provide coverage to the from-conception-to-end-of-pregnancy (FCEP) population (otherwise known as the "unborn"). No

PRA Disclosure Statement

V.20240322